

STATE	<u>Louisiana</u>
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1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Louisiana enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)  
1932(a)(1)(B)(ii)  
42 CFR 438.50(b)(1)

## 1. The State will contract with an

- ☐ i. MCO  
☐ ii. PCCM (including capitated PCCMs that qualify as PAHPs)  
☒ iii. Both

The State of Louisiana will contract with and enroll beneficiaries into two distinct types of MCEs:

- MCOs as “Coordinated Care Network-Prepaid (CCN-P)” entities; and
- Enhanced primary care case managers as “Coordinated Care Network-Shared Savings (CCN-S)” entities.

Program Overview

Beginning February 1, 2012 the State will implement Coordinated Care Networks (CCNs) through contracts with enhanced primary care case management (E-PCCM) entities (known as “Coordinated Care Network-Shared Savings” (CCN-S) and MCO (“Coordinated Care Network-Prepaid” (CCN-P)) entities. CCNs will be responsible for the development of care management and disease management strategies to meet the needs of their enrollees.

The BAYOU HEALTH program includes two Medicaid managed care models, which will be implemented simultaneously. Recipients will be given the opportunity to choose not only the type of model they will receive services, but will also have choice of which provider within each model. All CCNs will offer services statewide.

- The CCN-P is a traditional capitated MCO Medicaid managed care model in which entities establish a robust network of providers and receive a monthly payment (PMPM) for each enrollee to guarantee access to

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- specified Medicaid State Plan services (referred to as core benefits and services) and care management services. The CCN-P will also provide additional services not included in the Medicaid State Plan and provide incentive programs to their network providers. All plans will be paid the same actuarially determined risk adjusted rates.
- The CCN-S is an enhanced PCCM Medicaid managed care model in which the entity receives a monthly per-member fee to provide enhanced PCCM services and PCP care management, with opportunities for the CCN entity to share in any cost savings realized from coordinating care with PCPs. The CCN-S's network shall consist of primary care providers. All CCN-S are required to share a portion of savings received with providers and their plan to share savings must be approved by DHH.

In both models, the state program includes significant administrative monitoring and controls to ensure that appropriate access, services and levels of quality are maintained including sanctions for non-reporting or non-performance.

42 CFR 438.50(b)(2)  
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

- ☒ i. fee for service; (E-PCCM only)  
☒ ii. capitation; (MCO only)  
☒ iii. a case management fee; (E-PCCM only)  
☒ iv. a bonus/incentive payment; (E-PCCM only)  
☐ v. a supplemental payment, or  
☐ vi. other. (Please provide a description below).

\*For the CCN-S model, the State will pay the CCN-S, which is the primary care case manager, an enhanced primary care case management fee consisting of: (1) a primary care management fee and (2) an enhanced care management fee. The enhanced care management portion of the E-PCCM fee will be for care management activities such as additional disease management, assistance provided to PCPs with obtaining NCQA patient-centered medical home recognition, chronic care management, and prior authorization. The E-PCCM fee will be paid on a per member per month basis and will be subject to an annual incentive based on savings determined, performance under the contract and quality indicators.

\*\*For the CCN-P model, the MCOs will be paid actuarially sound capitation rates subject to actuarial soundness requirements at 42 CFR 438.6(c).

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1905(t)  
42 CFR 440.168  
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

- ☒ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
- ☒ ii. Incentives will be based upon specific activities and targets.
- ☒ iii. Incentives will be based upon a fixed period of time.
- ☒ iv. Incentives will not be renewed automatically.
- ☒ v. Incentives will be made available to both public and private PCCMs.
- ☒ vi. Incentives will not be conditioned on intergovernmental transfer agreements.
- ☐ vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (*Example: public meeting, advisory groups.*)

**Beginning in February 1, 2012, the State will incrementally implement the CCN models in three geographic service areas with complete implementation by June 1, 2012.**

The State established a website ([www.MakingMedicaidBetter.com](http://www.MakingMedicaidBetter.com)) to keep the public informed during the design of the CCN Program and provide current information on progress toward implementation. The website is a "one stop shop" for documents and information regarding CCNs and includes an online form that interested parties can submit electronically to provide suggestions or ask questions.

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A CCN Resource Guide for Providers was developed and is posted on the website to inform providers of the CCN Program and includes a program overview, timelines for implementation, how the DHH addressed provider concerns, CCN provider recruitment process, information to know about interacting with CCNs, CCN marketing guidelines, etc.

Meetings and presentations were made to legislative committees, advocates such as Covering Kids and Families Coalition, Louisiana Consumer Healthcare Coalition, Louisiana Maternal and Child Health Coalition, Interagency Council on Homelessness, and Office of Developmental Disabilities; associations such as the Louisiana Primary Care Association, Hospital Association, Louisiana Medical Society; health care providers such as physician groups, hospitals, transportation providers and health care plans. Nine public forums were conducted in each of the nine major geographic regions of the state (complete video of the meetings are available on the website.) See Attachment A for a listing of public meetings and provider meetings for the period of January 2010 through May 2011.

An emergency rule creating the CCN model was published in the eight major daily newspapers in Louisiana in September 2010 but was withdrawn to obtain greater public input. After obtaining additional input from stakeholders, the Notice of Intent (NOI) was published on February 20, 2011 in the *Louisiana Registry*. DHH solicited written comments and received 24 written comments which were each responded to individually. The public hearing on the Notice of Intent was held on March 30, 2011 with approximately 67 attendees. Feedback received during the administrative rulemaking process was incorporated into both the Request for Proposals issued April 11, 2011 and the Final Rule that was published in the *Louisiana Registry* on June 20, 2011. Copies of the proposed and final State Plan Amendment will be posted on the website. Public input will continue during and after the implementation of the program, through website recommendations, public meetings, provider meetings, and DHH CCN Member Advisory Council meetings, etc.

The final rule has been shared and the proposed State Plan Amendment will be shared with the four federally recognized Tribes in Louisiana (Coushatta, Chitimacha, Biloxi-Tunica, and Jena Band of Choctaws). Prior to the submittal of the State Plan Amendment pages to CMS, the Department will provide a notification letter to the tribal contacts for each of the four tribes and give them time to comment on the proposed amendment. The Department will continue to utilize every opportunity to engage the tribes post-implementation. DHH is in the process of developing a formal policy consistent with the Department of Health and Human Services Tribal Consultation Policy and Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) to ensure that input is provided on all State Plans that will likely have a direct impact or cost to Louisiana's Native Americans or Indian Health Programs (638 Clinics/FQHCs).

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Outreach and education for Medicaid enrollees who will be enrolled will begin in early October 2011. The Department has contracted for the development and implementation of a robust education and outreach campaign to primarily engage CCN-eligible Medicaid recipients in making a pro-active choice of a CCN to help the Department reach its goal of having at least 80 percent of new enrollees make a pro-active choice. This campaign will be developed in close consultation and coordination with the Department and Enrollment Broker with input from stakeholders. The contractor will use a strong mix of traditional and non-traditional media, direct mail and aggressive one-on-one outreach events to reach the target audience. The contractor will be responsible for all messaging, the development of ad creative and other collateral (including direct mail pieces, posters and other printed and digital material), training of Department staff and community-based organizations and planning of events.

In addition to DHH's marketing campaign to raise awareness of CCNs, the Medicaid/CHIP outreach infrastructure (eligibility employees throughout the state in concert with existing contracts with community based organizations) will be utilized to provide information and one-on-one assistance.

The Medical Care Advisory Committee meets quarterly and has been a forum for ongoing public involvement. The State has a cooperative endeavor agreement with the Louisiana Health Care Quality Forum and they are expected to play a sentinel role, along with the community based organizations with whom Medicaid has close relationships. The website [www.MakingMedicaidBetter.com](http://www.MakingMedicaidBetter.com) will be continually updated with information about enrollment and the public can send questions and comments to the e-mail address [coordinatedcarenetworks@la.gov](mailto:coordinatedcarenetworks@la.gov)

Each CCN is mandated to create a Member Advisory Council to allow participation in providing input on policy and programs. A member of each CCN's Member Advisory Council must also serve on DHH's Member Advisory Committee to provide input to DHH on the CCN Program.

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1932(a)(1)(A)	<p>5. The state plan program will <u>X</u>/will not ___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ___ / voluntary ___ enrollment will be implemented in the following county/area(s):</p> <p>i. county/counties (mandatory) _____</p> <p>ii. county/counties (voluntary) _____</p> <p>iii. area/areas (mandatory) _____</p> <p>iv. area/areas (voluntary) _____</p>

Until the CCNs are phased in statewide, the State will continue to operate the existing basic PCCM model (CommunityCARE 2.0) in those geographic regions in which CCNs have not been implemented. Statewide implementation is planned within a four month time span. Beginning in January 1, 2012, the State will incrementally implement the CCN models in three geographic service areas with complete implementation by May 1, 2012.

**C. State Assurances and Compliance with the Statute and Regulations.**

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

- |   |  |
|---|--|
| <p>1932(a)(1)(A)(i)(I)<br/>1903(m)<br/>42 CFR 438.50(c)(1)</p>                    | <p>1. <u>X</u> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.</p>  |
| <p>1932(a)(1)(A)(i)(I)<br/>1905(t)<br/>42 CFR 438.50(c)(2)<br/>1902(a)(23)(A)</p> | <p>2. <u>X</u> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.</p>  |
| <p>1932(a)(1)(A)<br/>42 CFR 438.50(c)(3)</p>                                      | <p>3. <u>X</u> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.</p> |
| <p>1932(a)(1)(A)<br/>42 CFR 431.51<br/>1905(a)(4)(C)</p>                          | <p>4. <u>X</u> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.</p>  |
| <p>1932(a)(1)(A)<br/>42 CFR 438<br/>42 CFR 438.50(c)(4)<br/>1903(m)</p>           | <p>5. <u>X</u> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.</p>  |

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1932(a)(1)(A)  
42 CFR 438.6(c)  
42 CFR 438.50(c)(6)

6. X The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

1932(a)(1)(A)  
42 CFR 447.362  
42 CFR 438.50(c)(6)

7. N/A The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.

45 CFR 74.40

8. X The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.
- Children (under 19 years of age) including those eligible under Section 1931 poverty-level related groups and optional groups of older children;
  - Parents, including those eligible under Section 1931 and optional groups of caretaker relatives;
  - CHIP (Title XXI) children enrolled in Medicaid-expansion CHIP (LaCHIP Phase I, II, & III);
  - CHIP (Title XXI) unborn option (Phase 4)
  - Pregnant Women: Individuals whose basis of eligibility is pregnancy, who are only eligible for pregnancy-related services, and whose eligibility extends 60 days after the end of the pregnancy;
  - Breast and Cervical Cancer Program: Uninsured women under age 65 who are not otherwise eligible for Medicaid and are identified through CDC National Breast and Cervical Cancer Early Detection Program. (Not applicable to CommunityCARE); and
  - Non-dually eligible Aged, Blind & Disabled Adults age 19 or older (note: dual eligibles are exempt and children are voluntary as noted below).
2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)  
42 CFR 438(d)(1)

- i.    Recipients who are also eligible for Medicare

If enrollment is voluntary, describe the circumstances of enrollment.  
(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)

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1932(a)(2)(C)  
42 CFR 438(d)(2)

- ii. X Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

**Note: Voluntary enrollment is allowed under the CCN Program.**

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1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. <u>X</u> Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. <u>N/A</u> Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.  Louisiana does not cover this optional group.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. <u>X</u> Children under the age of 19 years who are in foster care or other out-of- home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. <u>X</u> Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50 (3)(v)	vii. <u>X</u> Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

- 1932(a)(2)  
42 CFR 438.50(d)
1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (*Examples: children receiving services at a specific clinic or enrolled in a particular program.*)
- The State defines the above referenced children as those children receiving services at a Children's Special Health Services (CSHS) clinic Operated by the Louisiana Department of Public Health.**
- 1932(a)(2)  
42 CFR 438.50(d)
2. Place a check mark to affirm if the state's definition of title V children is determined by:
- X i. program participation (receipt of services at a CSHS clinic),  
 \_\_\_ ii. special health care needs, or  
 \_\_\_ iii. both
- 1932(a)(2)  
42 CFR 438.50(d)
3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, and coordinated care system.
- X i. yes  
 \_\_\_ ii. no

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1932(a)(2) 42.CFR 438.50 (d)	<p>4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: <i>(Examples: eligibility database, self-identification)</i></p> <p>i. Children under 19 years of age who are eligible for SSI under title XVI;</p> <p><b>These children are identified through system coding as Aid Category 04 and Type Case 78 in the MMIS recipient file.</b></p> <p>ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;</p> <p>N/A. Louisiana does not cover this optional group.</p> <p>iii. Children under 19 years of age who are in foster care or other out-of-home placement;</p> <p><b>These children are identified through coding as Aid Category 06, 08, or 22 in the MMIS recipient file</b></p> <p>iv. Children under 19 years of age who are receiving foster care or adoption assistance.</p> <p><b>These children are identified through coding as Aid Category 06, 08, or 22 in the MMIS recipient file</b></p>
1932(a)(2) 42 CFR 438.50 (d)	<p>5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. <i>(Example: self-identification)</i></p> <p><b>Caregivers of children are informed through required member materials that if they meet one of the identified special needs criteria that they may self-identify and request disenrollment through the enrollment broker.</b></p>

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1932(a)(2) 42 CFR 438.50(d)	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: (<i>Examples: usage of aid codes in the eligibility system, self-identification</i>). The following recipients are excluded and cannot voluntarily enroll in the CCN Program.</p> <p>i. Recipients who are also eligible for Medicare.</p> <p><b>The above referenced group is identified by specific coding (Medicare Indicator) in the MMIS recipient file.</b></p> <p>ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</p> <p><b>All enrollees are informed through required member materials that if they are a member of a federally recognized Tribe they may self-identify, provide documentation of Tribal membership, and request disenrollment through the enrollment broker.</b></p>
42 CFR 438.50	<p>F. <u>List other eligible groups (not previously mentioned) who will be exempt (excluded) from mandatory enrollment.</u></p> <p>i. Individuals receiving hospice services;</p> <p>ii. Individuals residing in Nursing Facilities (NF) or Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD);</p> <p>iii. Individuals who have been diagnosed with tuberculosis, or suspected of having tuberculosis, and are receiving tuberculosis-related services through the Tuberculosis Infected Individual Program;</p> <p>iv. Individuals receiving services through any 1915(c) Home and Community-Based Waiver (<u>other than the Louisiana Behavioral Health Partnership 1915(c) waiver</u>), including, but not limited to:</p> <ul style="list-style-type: none"><li>• Adult Day Health Care (ADHC) - Direct care in a licensed adult day health care facility for those individuals who would otherwise require nursing facility services;</li><li>• New Opportunities Waiver (NOW) - Individuals who would otherwise require ICF/DD services;</li><li>• Community Choices - Services to persons aged 65 and older or disabled adults who would otherwise require nursing facility services;</li></ul>

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- Children's Choice (CC) - Supplemental support services to disabled children under age 18 on the NOW waiver registry;
  - Residential Options Waiver (ROW) - Individuals living in the community who would otherwise require ICF/DD services;
  - Supports Waiver - Individuals 18 years and older with mental retardation or a developmental disability which manifested prior to age 22; and
  - Other HCBS waivers as may be approved by CMS.
- v. Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' (OCDD's) Request for Services Registry, also known as Chisholm Class Members;
- vi. Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete "managed care" type benefit combining medical, social and long-term care services;
- vii. Individuals with a limited eligibility period including:
- Spend-down Medically Needy Program - An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Medicaid coverage (up to three months); and
  - Emergency Services Only - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements;
  - Continued Medicaid Program - Short-term coverage for families who lose LIFC or TANF eligibility because of child support collections, an increase in earnings, or an increase in the hours of employment; and
- viii. Individuals enrolled in the Section 1115 Family Planning Waiver known as Take Charge that provides family planning services only to uninsured women ages 19 - 44 who are not otherwise eligible for Medicaid program.
- ix. Individuals enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) Program (Section 1906).
- x. Individuals enrolled in the Section 1115 Greater New Orleans Community Health Connections (GNOCHC) Waiver that provides coverage to adults for primary care.

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42 CFR 438.50	G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u> N/A
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1932(a)(4) 42 CFR 438.50	H. <u>Enrollment process.</u>
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1. Definitions

- i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.
- ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default.
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Describe how the state's default enrollment process will preserve:

- i. the existing provider-recipient relationship (as defined in H.1.i).

As part of the financial Medicaid and LaCHIP application process, applicants may be given the option to indicate their preferred choice of CCN and PCP. If the choice of CCN and PCP is not indicated on the new enrollee file transmitted by DHH to the Enrollment Broker, the Enrollment Broker shall contact the enrollee to request their choice of CCN and PCP. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a CCN.

Enrollment Broker staff will be available by telephone to assist program enrollees. Program enrollees will be offered multilingual enrollment materials or materials in alternative formats, large print, and/or Braille when needed. The enrollment broker shall assist the Medicaid enrollee with the selection of a CCN that meets the enrollee's needs by explaining in a non-biased manner the criteria that may be considered when selecting a CCN.

If no CCN choice is made, the enrollment broker will utilize available information about relationships with existing PCPs in the assignment process.

Medicaid potential enrollees who are eligible for CCN will have thirty (30) calendar days from the postmark date that an enrollment form is sent to them by the Enrollment Broker to select a CCN. All members of a family unit will be encouraged to select the same CCN.

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With the implementation of the CCNs in a geographic service area, enrollees will be given the chance to choose a CCN. Enrollees have 90 days from the initial date of enrollment into a CCN in which they may change the CCN for any reason. If the enrollee does not request a disenrollment from the CCN within 90 days, the enrollee will be locked-in to the CCN for up to 12 months, or until their next open enrollment period unless they are disenrolled for cause.

- ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

All CCNs will contract with providers who have traditionally served Medicaid recipients and will be available for choice and default assignment. Preexisting relationships are a factor in the auto-assignment algorithm.

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- iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). (Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)

**If there is capacity, the system then will auto-assign enrollees based on the State's algorithm to ensure an equitable distribution among qualified CCNs. Once a CCN reaches 65% of the market share in a geographic service area they will no longer receive auto assignments. (However potential members will be allowed to proactively select the CCN.)**

1932(a)(4)  
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

- i. The state will X /will not use a lock-in for mandatory managed care.
- ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.
- iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. (Example: state generated correspondence.)

**The State's enrollment broker generates confirmation letters to all enrollees who make a choice, or were auto-assigned to an available CCN. The letters are mailed to reach the enrollees by the 1st of the month that the enrollment is effective, and it provides the CCN contact information.**

- iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. (Examples: state generated correspondence, HMO enrollment packets etc.)

**The confirmation letter that is mailed by the enrollment broker to all enrollees that become linked by choice, change or auto-assignment states the enrollee may change MCO or E-PCCM or PCP without cause within 90 days of their enrollment.**

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- v. Describe the default assignment algorithm used for auto-assignment.  
(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)

Potential enrollees are auto-assigned based on the State's algorithm taking into consideration:

- The member's previous CCN;
- Inclusion in the CCN provider network of the member's historic provider as identified by Medicaid claims history
- If the provider with which the member has a historic provider relationship contracts with more than one CCN, the member will be assigned to a CCN with which the provider contracts, on a round robin basis;
- If the provider with which the family member has a current or historic provider relationship contracts with more than one CCN, the member will be assigned to a CCN with which that provider contracts, on a round robin basis;
- If neither the member nor a family member has a current or historic provider relationship, the member will be auto-assigned to a CCN with one or more PCPs accepting new patients in the member's parish of residence, on a round robin basis subject to CCN capacity; and
- Beginning in October 2014, the CCN's quality measures will be factored into the algorithm for automatic assignment.

- vi. Describe how the state will monitor any changes in the rate of default assignment. (Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)

The State will use regular reports generated by the enrollment broker to monitor CCN choice rates, auto-assignments, and disenrollments.

1932(a)(4)  
42 CFR 438.50

1. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. ☒ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

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2.	<u>X</u> The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).
3.	<u>    </u> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.  <u>X</u> This provision is not applicable to this 1932 State Plan Amendment.
4.	<u>    </u> The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

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☒ This provision is not applicable to this 1932 State Plan Amendment.

5. ☒ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

☐ This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)  
42 CFR 438.50

J. Disenrollment

1. The state will ☒ /will not ☐ use lock-in for mandatory managed care.
2. The lock-in will apply for 12 months (up to 12 months).

**NOTE: Or until the next open enrollment period, whichever occurs first.**

3. Place a check mark to affirm state compliance.

☒ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

**The State will evaluate requests for disenrollment for "cause" after the lock-in period on a case-by-case basis. Examples of additional circumstances for cause include:**

- moving out of the CCN geographic service area;
- the CCN does not, because of moral or religious objections cover the service the enrollee seeks; the enrollee needs related service to be performed at the same time;
- Contract between the CCN and DHH is terminated
- The member requests to be assigned to the same CCN as family members; or
- not all related services are available within the network (for CCN-P enrollees) and the enrollee's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)  
42 CFR 438.50  
42 CFR 438.10

☒ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

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L. List all services that are excluded for each model (MCO & PCCM)

**The following services are excluded from coverage under the CCN-P Model:**

- Dental;
- Hospice
- ICF/DD Services\*;
- Personal Care Services;
- Nursing Facility Services\*;
- Pharmacy Services (Prescription Medicines Dispensed)
- Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by OPH certified school-based health clinics);
- All Home & Community-Based Waiver Services;
- Specialized Behavioral Health;
- Targeted Case Management Services including Nurse Family Partnership; and
- Services provided through DHH's Early-Steps Program (Individuals with Disabilities Education Act (IDEA) Part C Program Services)

**\*Individuals receiving these services are excluded from enrollment or will be disenrolled from the CCN-P.**

Medicaid state plan covered services other than primary care case management services are covered and reimbursed outside of the CCN through the Medicaid fee-for-service payment system or other managed care programs. The CCN-S is responsible for authorizing all State plan covered service, except:

- Services provided through DHH's Early Step Services (IDEA Part C Program Services)
- Dental Services
- Personal Care Services (EPSDT and LT-PCS)
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Services\*
- Home & Community-Based Waiver Services
- Hospice Services\*
- Non-Emergency Transportation
- School-based Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district
- Nursing Facility Services\*
- Pharmacy (Prescription Drugs)

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	<ul style="list-style-type: none"><li>• <b>Specialized Behavioral Health Services</b></li><li>• <b>Targeted Case Management</b></li><li>• <b>Durable Medical Equipment and certain supplies</b></li><li>• <b>Prosthetics and orthotics</b></li></ul>

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1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will X /will not\_\_\_ intentionally limit the number of entities it contracts under a 1932 state plan option.
2. X The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.
3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

Contractors were determined through a competitive procurement process. The number of CCNs will be limited to 3 per model (CCN-P or CCN-S) per geographic service area. The State's contracted Medicaid fiscal intermediary, its subsidiary companies, parent, or affiliated entities cannot also participate in the Louisiana Medicaid program as a Medicaid provider, CCN-P or CCN-S.

\_\_\_ The selective contracting provision is not applicable to this state plan.

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